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ABSTRACT

This guide is intended to help schools develop linkages with the federal Medicaid program, particularly the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) program, a comprehensive and preventive health care system for Medicaid-eligible individuals up to age 21. The guide aims to: (1) acquaint schools with State Medicaid agencies and the EPSDT program; (2) discuss how schools can develop or augment EPSDT outreach and health service programs; (3) direct schools to additional sources of information; and (4) illustrate some different types of linkages between schools and the EPSDT program. Chapter 1 introduces the EPSDT program, while chapter 2 describes the program in more detail and outlines the services that the program provides. Chapters 3 and 4 focus on school roles in EPSDT, including outreach case management and service delivery. Chapter 5 reviews examples of successful partnerships between local educational systems and EPSDT programs, and highlights the school's role in conducting outreach activities, screening, and providing a full range of services. Two appendixes provide lists of regional and state contact persons and agencies at the federal and state level that help administer the EPSDT program. (MDM)

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EPSDT

A Guide For Educational Programs

U.S. Department of Health and Human Services
HEALTH CARE FINANCING ADMINISTRATION
MEDICAID BUREAU

SEPTEMBER 1992

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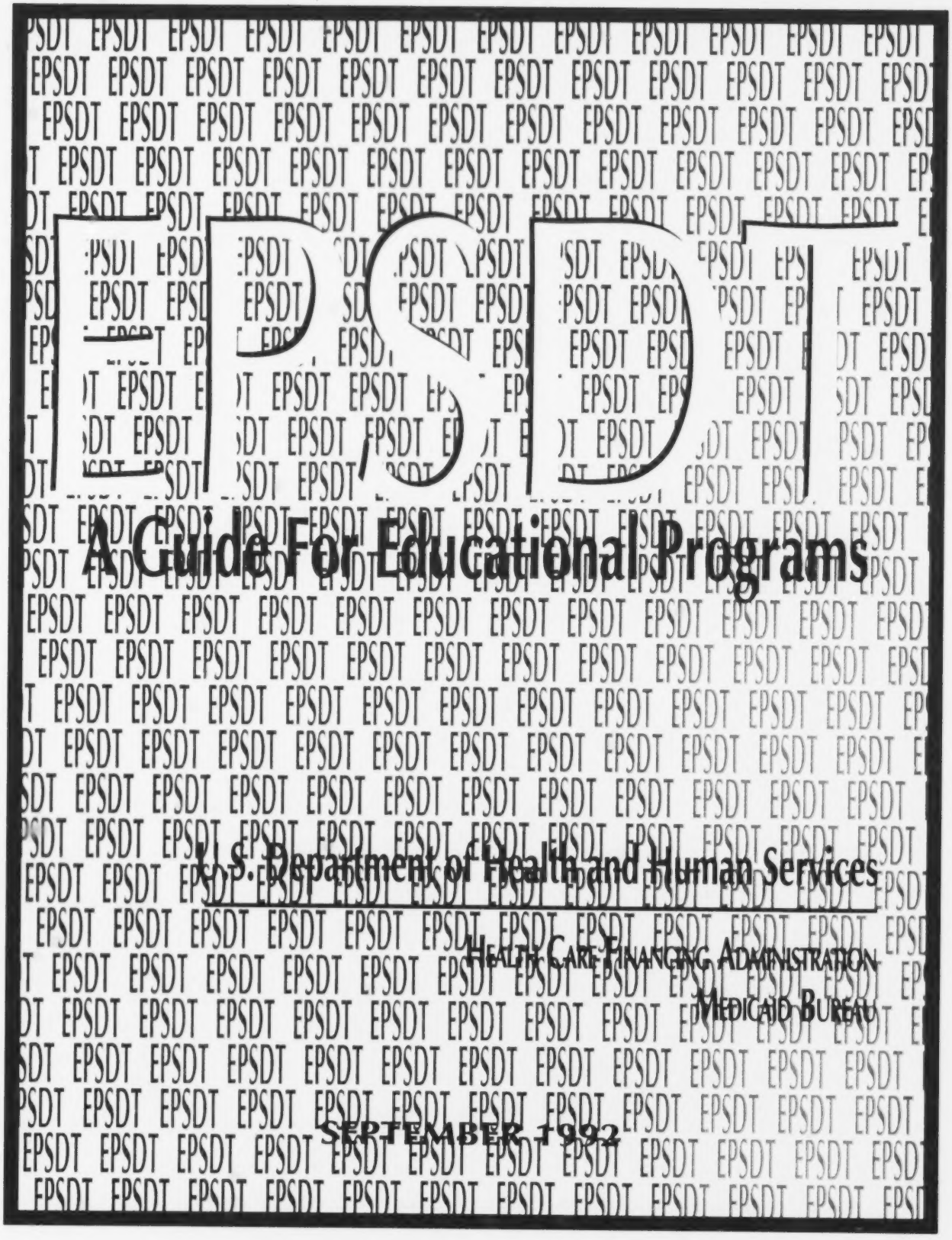
EPSDT
A Guide For Educational Programs
U.S. Department of Health and Human Services
HEALTH CARE FINANCING ADMINISTRATION
MEDICAID BUREAU
SEPTEMBER 1992

A MESSAGE FROM THE MEDICAID BUREAU DIRECTOR

The Health Care Financing Administration is committed to helping schools and other educational entities ensure that their students are healthy and ready to learn. To that end, we prepared this guide for an overview of Medicaid's health program for children: the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) program.

As the Introduction tells us, the guide has several purposes:

- to acquaint schools with State Medicaid agencies, the EPSDT program and the benefits of participating;
- to discuss how schools can develop or augment EPSDT outreach and health service programs;
- to direct schools to additional sources of information; and
- to illustrate some different types of linkages between schools and the EPSDT program.

Our guide does not pretend to have all the answers. However, to the extent that we can give you a better understanding of the EPSDT program, we believe we are taking a major step forward in our efforts to better serve Medicaid-eligible children. Please do not hesitate to get in touch with the Medicaid contact people from the various States and HCFA regional offices who are listed in the text and its attachments. They can provide you with information on program policy and creative effective practices around the country which you may find useful.

We at HCFA know how instrumental our country's schools can be in promoting and helping implement health programs for needy children. We hope that this guide will contribute to a fruitful dialogue in the interests of improving the health and wellbeing of those young people who need assistance the most.

Thank you so much for your help in this endeavor.

Christine Nye
Director

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1. INTRODUCTION

Children receiving appropriate health services are better prepared to succeed in school, and in life, since poor health can interfere with the learning process. Many schools have begun addressing the health care needs of students in recognition of the importance of good health for academic success. The Health Care Financing Administration (HCFA) encourages these efforts. HCFA is committed to assisting schools and other educational entities in ensuring that the full learning potential of Medicaid-eligible children is not threatened by poor health.

Schools can play an important role in identifying children's health problems and improving access to a wide range of health care services by building on the existing system of child health services in their communities. Schools are well situated to provide a linkage between the family and health and social services, since they have access to the majority of children and adolescents in the country on a daily basis. Simply put, schools are where children are.

This guide was written to assist schools in developing linkages with Medicaid, particularly the Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) program, a comprehensive and preventive health care program for Medicaid-eligible individuals up to age 21. Through EPSDT Medicaid-eligible children receive health screenings, as well as medically necessary diagnostic and treatment services for conditions found through the screenings.

At the outset, Medicaid, Title XIX of the Social Security Act, is a Federal-State matching entitlement program which provides medical assistance for certain low-income individuals and families. Administered by States within broad Federal guidelines, Medicaid programs may vary considerably from State to State and over time. Differing from many public health grant programs, Federal contributions follow and are based on State expenditures for covered medical assistance.

A. Purpose of the Guide:

At the outset, schools and others interested in pursuing linkages with EPSDT begin their planning with their State's Medicaid agency. This guide aims to: (1) acquaint schools with State Medicaid agencies and the EPSDT program; (2) discuss how schools can develop or augment EPSDT outreach and health service programs; (3) direct schools to additional sources of information; and (4) illustrate some different types of linkages between schools and the EPSDT program.

We hope this guide will help school and other educational program staff (e.g. Head Start, Even Start, Chapter 1 Pre-K) interested in increasing access to preventive and treatment services for their Medicaid-eligible students; and encourage and assist State education agencies, local education agencies, State and local health agencies, and others in becoming actively involved in their State's EPSDT program by using the school setting as one resource in a total system of health care. Parents, community groups, and others may also find that this guide helps them understand and participate in the EPSDT program.

In addition, regional Health Care Financing Administration, Public Health Service, and Department of Education staff may use this guide to provide technical assistance to States and school districts interested in developing effective models for providing EPSDT outreach, case management, and service

delivery.

The guide does not pretend to provide all of the answers. Each State and local area has its own unique health and educational system to consider when developing or enhancing a collaborative program.

B. The Benefits of School/EPSDT Linkages

For children receiving publicly funded health care, the importance of preventive and early intervention services cannot be overlooked. Resources invested in prevention can save public funds in the long run. The EPSDT program allows providers, including schools, to be reimbursed for preventive and treatment services for Medicaid-eligible children.

Preventive health services are especially important for young children, as illnesses and handicaps not treated in childhood can easily become barriers to achievement in school and in society. Adolescents are also an important target population for school health care services, because they tend not to be linked with community services, as reflected in low EPSDT screening rates for this population.

The development of relationships with Medicaid providers offers schools an opportunity to improve the quality and scope of all their health programs. Furthermore, many schools have turned to Medicaid and EPSDT to finance health care for certain students with disabilities as required by law. Through EPSDT screening services, Medicaid-eligible children with disabilities can be identified and provided necessary treatment. EPSDT may cover case management services which can be particularly important for students with disabilities who have complex health, education, and social service needs. A case manager can assist these children in accessing and scheduling needed care.

Finally, in addition to providing services, schools can play a critical role in linking children with health care and other services in the community. Many communities have established systems for children's health care that involve providers such as physicians and dentists in local practice, public maternal and child health programs, health departments, and community health centers. By establishing relationships with community providers and programs, schools can help connect students with needed services. Such linkages and communication can also save money and staff time by avoiding duplication of services.

C. The Schools and Medicaid Eligible Students

To improve the continuing low participation rates, in 1989 Congress mandated that the Secretary of the Department of Health and Human Services (DHHS) establish EPSDT participation goals. The goals state that, by FY 1995, all States should screen 80% of eligible children due to be screened. While we do not know exactly how many children receive EPSDT services through schools, it is clear that additional children could be reached through appropriate school participation in outreach, case management, screening, or other health service activities.

D. Organization of the Guide

The guide is divided into five chapters followed by appendices listing additional information resources. This first chapter is an introduction to the guide and defines its purpose and organization. The second chapter describes the overall EPSDT program

and helps schools understand who is eligible for services, what services are covered, who can provide them, and finally discusses key Medicaid principles that must be followed for a successful school EPSDT program. The third chapter describes the EPSDT process, beginning with outreach and ending with treatment or renotification of the child and family if no health care problems were found through screening.

The last two chapters of the guide focus on linkages between schools and EPSDT programs. Chapter four describes three major roles for schools in the EPSDT program: outreach, case management, and service delivery. In the final chapter there are descriptions of school/EPSDT linkages across the country and a comparison of these programs. The examples of linkages between the schools and EPSDT programs should be particularly helpful to schools because they show the variety of arrangements that are possible. In addition, each example includes a contact person who is available to answer questions and provide further information.

At the end of the guide, appendices list various resources for additional information.

2. EPSDT PROGRAM ELEMENTS

This chapter briefly outlines the complex Medicaid program and its EPSDT component. We encourage school personnel to contact State Medicaid programs (see Appendix B) if they have questions or need additional information.

A. Overview

Established in 1966, Medicaid is an entitlement program which finances medical services for certain individuals and families with low incomes and resources. Within broad Federal guidelines a State or Territory: (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rates of payment for services; and (4) administers its own program. The Federal-State jointly funded Medicaid program varies considerably from State to State as each State adapts the program to its own unique environment.

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program is a preventive and comprehensive health program for Medicaid-eligible individuals under age 21. Each element of the program's name combine to make the EPSDT program unique:

Early: assessing a child's health early in life so that potential diseases and disabilities can be prevented or detected in their preliminary stages, when they are most effectively treated.

Periodic: assessing a child's health at regular recommended intervals in the child's life to assure continued healthy development.

Screening: the use of tests and procedures to determine if children being examined have conditions warranting closer medical or dental attention.

Diagnosis: determination of the nature and cause of conditions identified by screenings.

Treatment: the provision of services needed to control, correct, or lessen health problems.

To administer EPSDT, State Medicaid agencies:

- Seek out eligible children and families to:
  - — Encourage their enrollment in EPSDT,
  - — Inform them of the availability and benefits of preventive services,
  - — Provide assistance with scheduling and transportation,
  - — Help them use health resources effectively and efficiently;
- Assess health needs through initial and regular periodic examinations;
- Assure that detected health problems are diagnosed and treated early, before they become more complex and their treatment more costly.

In addition, State Medicaid agencies and EPSDT providers are encouraged to ensure children receive appropriate services on a timely basis.

A State EPSDT program is often part of a larger web of linked organizations and programs for children. Coordination is essential to preventing duplication of services while maximizing children's access to needed services. Medicaid agencies are required to coordinate services with Maternal and Child Health (MCH) Programs, and the Special Supplemental Food Program for Women, Infants, and Children (WIC). Medicaid agencies are expected to coordinate with additional programs such as Head Start, State and local educational agencies, and social services. Agencies may develop interagency agreements, make appropriate cross referrals, establish child health coordinating committees, and initiate other activities to facilitate coordination.

B. Eligibility: Who Can be Served?

It is important that school personnel have a basic understanding of Medicaid eligibility to know generally which children are covered for EPSDT services and which children are not. However, because eligibility rules are so complex, school staff need to work closely with Medicaid program staff to make their school program effective. Most children under age 21 who are eligible for Medicaid are automatically eligible for EPSDT services and can receive EPSDT services at any time. But there are several exceptions. For example, family income is one of the main criteria used for eligibility determination, but not all children in families with incomes below the federal poverty level are eligible for Medicaid.

States have some discretion in determining which groups their Medicaid programs will cover and the financial criteria that will be used for Medicaid eligibility, but they must work within Federal requirements and cover certain groups. There are three broad types of Medicaid eligibility categories:

- mandatory categorically needy (States must cover);
- optional categorically needy (States may cover); *and*
- medically needy (States may cover).

Most categorically needy children under age 21 who are eligible for Medicaid are automatically eligible for EPSDT services. EPSDT services may be covered at State option for the medically needy population.

Mandatory Categorically Needy

To be eligible for Federal funds, States are required to provide Medicaid coverage for most individuals who receive Federal income-maintenance payments, as well as for related groups not receiving cash payments. The following are the mandatory Medicaid eligibility groups that include children under age 21:

- Recipients of Aid to Families with Dependent Children (AFDC);
- Supplemental Security Income (SSI) recipients;
- Infants less than 1 year old born to Medicaid-eligible pregnant women;
- Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act;
- Children under age 6 and pregnant women who meet the State's AFDC financial requirements as well as children whose family income is at or below 133 percent of the Federal poverty level.

In addition, States are required to extend Medicaid eligibility to all children up to age 19 born after September 30, 1983 in families with incomes at or below 100% of the Federal poverty level. This phases in coverage so that by the year 2002, all children under age 19 in such families will be covered.

Optional Categorically Needy

States also have the option to provide Medicaid coverage for other "categorically needy" groups. These optional groups share characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined. One such optional categorically needy group is children under age 21 who meet income and resources requirements for AFDC but because of their family structure (i.e. two parents in the household) are not eligible for AFDC.

Medically Needy

Another state option is to have a "medically needy" program which allows States to extend Medicaid eligibility to people who have too much income to qualify under the mandatory or optional categorically needy levels. These people become Medicaid-eligible by offsetting their excess income with medical expenses, a process known as spenddown. If a state chooses to provide EPSDT to any medically needy group, it must make EPSDT-related services available to all individuals within the group.

Eligibility is complicated and criteria vary significantly from state to state. Schools should contact their State Medicaid office for more specific information on Medicaid eligibility.

C. State EPSDT Requirements: What Services are Covered?

To participate in the Medicaid program, each State must develop a State plan which specifies how the State will meet various Federal statutory and regulatory requirements. Among the requirements is that States must make available certain services to Medicaid-eligible individuals, such as inpatient hospital services, outpatient hospital services, laboratory and x-ray services, physician services, EPSDT services, etc. In addition, the State may choose to cover any of approximately thirty optional services (e.g. dental services, physical therapy, and/or eyeglasses). In the State plan, the State must specify which optional services they will cover.

The EPSDT program is unique because the scope of required services is broader than for the Medicaid program in general. For

example, while dental services are available at State-option for the general Medicaid population, all States are required to cover dental services for EPSDT-eligible individuals. The rest of this section is an overview of EPSDT program requirements.

The following are required EPSDT services:

- screening services:
  - — a comprehensive health and developmental history (which includes a physical and mental health assessment),
  - — a comprehensive unclothed physical exam,
  - — appropriate immunizations according to age and health history,
  - — laboratory tests (including blood lead level),
  - — health education (including anticipatory guidance);
- dental services;
- hearing services, including hearing aids;
- vision services, including eyeglasses;
- any other necessary health care to correct or ameliorate illnesses and conditions found in screenings.

The services are to be available in accordance with a state's periodicity schedule (or timetable), which must be established separately for screening, dental, vision, and hearing services and must meet reasonable standards of medical practice. States must work with recognized medical and dental organizations involved in child health care in developing periodicity schedules. Screening services are also covered at times other than the regularly scheduled intervals if there is reason to suspect an illness or condition that did not exist at the time of the regular periodic screen.

In general, covered EPSDT diagnostic and treatment services include all required and optional Medicaid services, even if a State chooses not to cover a particular optional service for its general Medicaid population. Diagnostic services are covered whenever a screening examination indicates the need to conduct a more in-depth evaluation of the child's health status. Treatment services are covered whenever they are medically necessary to correct or ameliorate defects, physical or mental illnesses, or other conditions discovered (or found to have worsened) through an EPSDT screening.

State Medicaid programs must also provide certain support services under the EPSDT program. These include offering and providing assistance with transportation and with scheduling appointments in order to ensure that recipients obtain needed EPSDT services. Similarly, assistance with referrals should be provided when Medicaid does not cover the needed treatment services.

States are required to reach out to ensure that all eligible Medicaid recipients under age 21, and their families, are informed about EPSDT. States have the flexibility to determine how outreach and information dissemination will be conducted but they must ensure that all EPSDT-eligible children are effectively reached, generally within 60 days of the individual's Medicaid eligibility determination.

Outreach is critical in bringing EPSDT-eligible children into appropriate care and services. Through outreach, schools can play a significant role in reducing the number of children who are enrolled in Medicaid but are not receiving needed EPSDT services. Similarly, schools can encourage eligible children and families to enroll in Medicaid in the first place.

D. EPSDT Providers: Who Provides Services?

State Medicaid agencies certify a variety of qualified health care providers to furnish EPSDT services: physicians, dentists, or other providers qualified under State law to furnish medical and health services. This includes nurse practitioners in States where they are authorized to provide services.

Although a State Medicaid agency may elect to designate EPSDT screening providers who provide the entire package of screening services, it may not limit providers only to those who can provide all EPSDT diagnostic and treatment services. Close coordination should be maintained if more than one provider is needed to provide the full range of EPSDT services to a child. Services may be provided within schools, Head Start programs, State and local health departments, and other locations.

E. Reimbursement under Medicaid: How Much is Paid for Services?

State Medicaid agencies set rates and make payments for covered services provided Medicaid eligible recipients. Qualified Medicaid providers are reimbursed through prepaid arrangements or as a result of claims filed for services provided. State Medicaid agencies then file claims with HCFA for Federal reimbursement or financial participation in the expenditures made. The State's administrative expenditures for functions such as outreach, follow-up, eligibility determination, provider relations, and some transportation activities, are usually Federally matched at a fixed rate of 50%. Expenditures for the cost of medical services, including screening, diagnosis, and treatment, are Federally matched at varying rates depending on each State's relative per capita income. This rate varies from 50% to 83%, with poorer States receiving a higher match and wealthier states receiving a lower match.

Reimbursement for EPSDT case management activities is more complex: some activities can be classified as an administrative expenditure and some as a medical service expenditure. In some instances a particular case management activity may be claimed as either an administrative or medical service expenditure and the provider must decide how to classify the activity. For example, arranging transportation for a recipient to receive EPSDT services may be considered an administrative activity if conducted by a State Medicaid worker or a medical service if conducted by a nurse practitioner in a clinic.

F. Key Medicaid Principles

When developing linkages to the EPSDT program, schools must follow certain fundamental Medicaid principles, which are statutory and regulatory requirements. Schools should be aware of these principles and work with the state agency to meet them. The fundamental principles are: preserving confidentiality, billing liable third parties, reimbursing for services that would not otherwise be provided without charge, and assuring recipient freedom of choice of providers.

First, preserving confidentiality is of the utmost importance when providing Medicaid services. Both medical information and information on participants in the Medicaid program are assured protection. Medical information is always privileged and may only be released with the patient's permission. The use or disclosure of information concerning Medicaid applicants and recipients is restricted to purposes directly connected with

the administration of the State Medicaid plan, such as establishing eligibility, conducting a specific outreach program, determining the amount of medical assistance, and providing services for recipients. The state Medicaid agency must have criteria specifying the conditions for release and use of information about applicants and recipients.

The most difficult confidentiality issue for schools is how to identify Medicaid-eligible students in the school. If under a specific agreement with the State Medicaid agency in some states, schools are involved in bona fide administrative activities related to the state plan, like outreach or certain case management activities, the school may obtain lists of Medicaid-eligible students from the state. However, the lists may be used only for the defined administrative purpose, and the school is subject to the same requirements as if it were the State Medicaid agency itself. Outside of performing that administrative function, schools may only request information to verify the Medicaid enrollment status of a particular student. Schools should contact their state Medicaid agency for conditions on the release of information.

Second, Medicaid providers are normally responsible for billing liable third parties, such as private health insurance, prepaid health plans, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), before billing Medicaid. However, an exception is made for preventive pediatric care, including early and periodic screening and diagnosis services. For pediatric preventive care, the provider can bill Medicaid first before pursuing third party reimbursement. This is known as "pay and chase." EPSDT treatment services are not covered under this exception.

Third, the Federal government does not generally match State expenditures for services to Medicaid eligible children where the services are duplicated, or are available to all children without charge. HCFA's long standing rule is that the provider must either bill all individuals receiving the services, or at least bill all individuals who have third party coverage. (Exceptions to this principle include services furnished under Title V of the Social Security Act and certain services to children with disabilities provided under the Individuals with Disabilities Education Act that are specified in a child's Individual Education Plan or Individual Family Service Plan.)

Ideally, EPSDT services are part of a continuum of care where the child's health care services are delivered by someone familiar with the child's health history and family. Such a continuum or medical home is an objective of Medicaid coordinated or managed care programs. Coordinated care providers may also provide dental services and transportation and scheduling assistance.

If the State Medicaid agency includes EPSDT in its capitated arrangements as part of its Medicaid managed or coordinated care program, a school may be required to obtain authorization from or bill the health maintenance organization in order to be reimbursed for a service. In States with Medicaid primary care case management programs, the school would seek authorization from or bill the physician who is the child's primary care provider. Finally, in the absence of certain Federal waivers including those for managed care arrangements, Medicaid recipients have the freedom to choose their providers. Schools may encourage, but may not require, Medicaid-eligible students to receive EPSDT services through the school.

3. EPSDT PROGRAM ACTIVITIES: SCHOOLS CAN PLAY A ROLE.

So long as it complies with Federal requirements, a State has considerable discretion in administering its EPSDT program. Nevertheless, an expected sequence of EPSDT activities is outlined in Medicaid program instructions furnished in Part 5 of the State Medicaid Manual. Schools can play a role in many of the EPSDT activities, especially outreach, screening, diagnosis, and treatment.

A. Outreach/Informing

States conduct outreach related to both Medicaid in general and EPSDT in particular. States conduct outreach campaigns and activities to inform and recruit eligible individuals into the Medicaid program. States may advertise the importance and the availability of health services on radio and TV, in newspapers, and on billboards. Some States advertise toll-free numbers to call for information. This outreach can be broad-based or targeted toward particular groups such as pregnant women. The State may conduct the outreach with its own staff or may work through public and private organizations throughout the State.

In addition to broad-based outreach, States are required to ensure that all eligible Medicaid recipients under age 21 be informed about EPSDT within 60 days of their Medicaid eligibility determination. Both States and providers inform eligible individuals about the program and emphasize the importance of preventive health care.

Schools can help to inform eligible children and families about the EPSDT program, as is done in Baltimore, Maryland (see Chapter 5). The major advantage that schools have in this activity is their daily access to the student population which other programs (e.g. AFDC) cannot provide. Through these students, schools can also reach students' younger siblings who are not yet in school. In Baltimore, school nurses educate Medicaid-eligible students about the benefits of receiving EPSDT preventive health services.

B. Eligibility

The eligibility of a family for Medicaid, which includes EPSDT services, is usually determined by an eligibility worker in a local social service agency. If a child is determined to be Medicaid eligible, the child and family must decide whether or not to participate in the EPSDT program.

An initial decision to decline EPSDT services does not preclude a child's obtaining such services at a later time. Every year, however, individuals who have previously declined services are encouraged to participate in the EPSDT program. Schools may play a role in encouraging EPSDT participation. Families who accept EPSDT services proceed to the next step of arranging an appointment for health screening.

C. Scheduling an Appointment

The family can make an appointment for screening services individually or the Medicaid agency staff can help set up an appointment for the child. The Medicaid agency must offer and provide transportation assistance to appointments to those in need.

A State Medicaid agency may establish a facilitation strategy wherein schools can also provide scheduling and transportation assistance, as is done in Baltimore by school nurses. Such assistance is part of the case management services offered to Medicaid-eligible students. School nurses also link

students with providers and conduct follow-up.

D. Screening

Another activity for schools participating in the EPSDT program is to provide screening services. These include:

- a comprehensive health and developmental history (which includes a physical and mental health assessment);
- a comprehensive unclothed physical exam;
- appropriate immunizations according to age and health history;
- laboratory tests (including blood lead level);
- health education (including anticipatory guidance).

Although an oral screening examination may be part of a physical examination, it does not substitute for examination through direct referral to a dentist. A direct dental referral is required for every child in accordance with the dental periodicity schedule and at other intervals if medically necessary.

E. Assessment of Results

Results of the screening tests and procedures should be noted in the child's health record as soon as they are available. In those cases where no abnormalities or disabilities are indicated, the State Medicaid agency or school need only notify the child or family when the next periodic screening examination is due.

Cases where problems are indicated should be referred for diagnosis. In Louisiana, schools provide screening services and refer students to the community health center for diagnosis. In some cases, diagnosis and treatment services can be provided by the screening provider, if, for example, the child is receiving care from a continuing care provider. In Hartford, Connecticut, school-based clinics furnish screening, diagnostic, and treatment services.

F. Diagnosis

The purpose of diagnosis is to determine the nature, cause, and extent of the problem found by the screening examination. Diagnosis leads to the development of a plan for treatment.

G. Treatment

Treatment services are covered whenever they are medically necessary to correct or ameliorate defects, physical or mental illnesses, or other conditions discovered through an EPSDT screening. As discussed previously, covered EPSDT treatment services include all required and optional Medicaid services, even if a State does not cover a particular optional service for State Medicaid recipients in general.

Providers of services may not be limited to those qualified to furnish all diagnosis and treatment services. However, children in coordinated or managed care arrangements will receive almost all of their EPSDT screening, diagnosis, and treatment services from the same provider.

4. POTENTIAL EPSDT ROLES FOR SCHOOLS

A. Introduction

The health of children has been recognized as important by both educators and health professionals. Schools are key links in improving child health because they are in regular contact with students and parents. They can see health problems and help put families and health care providers in touch.

This chapter describes the three potential major roles schools can play in the EPSDT program: outreach, case management, and service delivery. EPSDT services may be part of an overall school health program that draws on multiple funding sources (e.g. Medicaid, private insurance, and school funds) and builds on existing community providers (e.g. State MCH Programs, local health departments).

B. Outreach

In providing the outreach activities determined by the State's Medicaid agency, schools have the opportunity to inform their school population about the importance of preventive health care and to encourage eligible children and families to participate in the EPSDT program. Key elements of an outreach strategy include: describing what EPSDT is, promoting the advantages of early detection and treatment, delineating how to participate in the program, and listing the EPSDT and support services that are available. The following outreach activities can be conducted by schools:

- contacting individual students and families through school staff;
- sending personal letters to students and their families from the school;
- organizing parent groups or individual parents to reach out and encourage other eligible parents to participate;
- developing and disseminating posters, booklets, and related educational materials;
- conducting health fairs on child health which emphasize preventive health care and promote EPSDT.

Before developing a strategy for conducting EPSDT outreach activities in its community, a school needs first to relate to the plans of the State Medicaid agency and to assess existing community outreach programs to prevent duplication of services.

As noted previously, one of the challenges for schools in conducting outreach is preserving the confidentiality of recipients. Medicaid status is not public information and may only be divulged to others with written consent by the family or for certain administrative activities. If a school does not have access to a list of Medicaid-eligible students, outreach must be directed towards all students in a school.

C. Case Management

The purpose of EPSDT case management is to assist children in navigating the often confusing system of health and related services in their communities. Since EPSDT screening, diagnosis, and treatment activities are frequently not conducted at one time or in one place, case management is critical to ensure that a child receives appropriate services on a timely basis. Among other activities, case managers:

- assist families in identifying and choosing providers;
- use the school as a resource in scheduling appointments and in

providing transportation;

- facilitate contact between the EPSDT program and the family to verify what activities have taken place, to maintain records, and to assure a timely flow of information;
- conduct follow-up to assure children receive needed diagnosis and treatment;
- help families maintain contact with providers;
- provide ongoing service coordination to answer questions and reduce fear and confusion.

Again, the State Medicaid agency determines who are qualified to provide EPSDT case management services. Some schools may be well suited to assisting in the case management role. Schools currently perform a variety of administrative tasks which are similar to case management services needed for EPSDT. For example, schools track the progress of students from one year to the next and refer children to special types of education programs. Schools can adapt these skills to support EPSDT case management in many ways.

D. Service Delivery

There are three basic roles for schools in delivering EPSDT services to students:

- providing screening and referrals;
- providing screening and some treatment services;
- full-scale service provision.

To conduct EPSDT screening services at the school, schools must employ, or contract with, qualified health personnel as specified in Federal and State regulations. Many schools use nurses or nurse practitioners to conduct EPSDT screens on-site. Students are referred to community providers for diagnosis and treatment services when such services are not available at the school.

In order for Medicaid to pay for services provided by schools, there must be a provider agreement between the State and the actual provider of services. If the school or school district employs health professionals or operates a school-based clinic which contracts with some of the required health professionals, the school or school district may qualify as the provider, bill Medicaid, and receive payment. Where the school or school district contracts with the necessary health professionals to provide discrete Medicaid services (e.g., physicians services, physical therapy, or speech therapy) the provider agreement must be executed between the State Medicaid agency and the health professional. If the school district will bill for the services of such health professionals' contract, there must also be an agreement for voluntary reassignment of payment between the provider and the school or school district. Above all, schools and school districts should work with their State's Medicaid agency as well as HCFA to determine the most viable means of accomplishing school-based health programs.

Some schools provide more than screening services. Increasingly, schools are furnishing services on-site, particularly services for children with disabilities such as occupational, speech, and physical therapy. Schools with comprehensive school-based clinics are able to offer a range of health care services to students, including treatment services to address conditions found through EPSDT screens. As schools well know, providing diagnostic and treatment services in addition to screening requires a bigger investment of resources, but these resources dramatically increase children's access to health care. Schools furnishing these services need to meet all applicable Federal and State standards.

In this guide it is not possible to cite all of the potential variations of these three basic service delivery roles, but it is useful for educators seeking to bring EPSDT into their schools to consider some of the examples described in chapter 5 of this guide. It is important to remember that there is no "best" or "correct" way for schools to relate to EPSDT since the populations, political will, and resources will vary greatly between communities.

5. EXAMPLES OF PROGRAM LINKAGES

A. Introduction

Schools and EPSDT programs have collaborated in a variety of ways in locations across the country. This chapter describes and compares several examples of linkages between local educational systems and EPSDT programs. This is not an exhaustive list; these particular examples were chosen because they demonstrate the scope of possible arrangements for these partnerships. Although the number of examples provided in this guide is small, these examples may contribute to an understanding of workable, practical approaches to building relationships between EPSDT and schools.

When reviewing the examples, schools should consider the following questions about the structure of the linkage:

- What services are provided in the school?
- What types of providers are used?
- Who bills Medicaid for services?
- To whom are services targeted?
- How will the school serve children in Medicaid managed care arrangements, where they are restricted to certain providers?

These questions will be examined more fully in the comparison that follows the descriptions of the individual partnerships.

B. Examples of Linkages

Baltimore, Maryland

Summary:

In Baltimore, children receive EPSDT outreach, case management, screening, and treatment services through the public schools. The city receives state funds for school nurses to conduct EPSDT outreach and case management for Medicaid-eligible students in schools. EPSDT services are provided in 10 school-based clinics run primarily by the city health department. In addition, the city has successfully developed a mechanism for providing EPSDT services through schools for children enrolled in HMOs and other arrangements that limit the providers they are authorized to see.

Description:

The State of Maryland contracts with each of its counties and Baltimore City to assist with EPSDT administrative duties, including outreach and follow-up. The State requires each subdivision to conduct outreach to Medicaid-eligible newborns but allows each to choose other populations to target as well.

Baltimore City uses part of the State grant to pay a portion of school nurses' salaries for EPSDT outreach and case management services in city schools. Approximately 25% of school nurses' salaries are offset by the grant money for EPSDT activities. The nurses are responsible for informing Medicaid-eligible children about the EPSDT program, making appointments for screens, arranging for free transportation and other needed support services, and determining if the child kept the appointment.

Not all Baltimore schools have nurses since there are 184 schools in the city and fewer than 50 school nurses. However, many of the schools with significant populations of Medicaid-eligible children employ school nurses. The city has been targeting high-school and middle-school-age children since the program began in 1985 because of the compelling health care needs of these children. However, the City is now shifting resources to elementary schools to provide and encourage preventive care earlier in children's lives. In State Fiscal Year 1991, the city provided case management to approximately 2,500 children, most of whom were teenagers.

In addition to receiving outreach and case management services through school, eligible children in Baltimore are provided EPSDT services through 10 school-based clinics in the city. Eight of the clinics are run by the Baltimore City Health Department—two are in middle schools, five are in high schools, and one is in a school for pregnant teens. The other two clinics are in middle schools and are run by non-profit agencies. For the city-run clinics, the schools contribute the space while the health department is responsible for the remaining costs (supplies, personnel, etc.).

In addition to providing EPSDT screens, the clinics provide a full range of services including acute care, management of chronic diseases, mental health services, substance abuse counseling, and sports physical exams. Children receiving services who are not covered by Medicaid are billed for services based on a sliding fee scale.

In December 1991, Maryland implemented the Maryland Access to Care Initiative (MAC) which links eligible children with a particular provider to ensure they have a medical home. MAC requires every Medicaid-eligible child under age 21 to be assigned to a primary medical provider or enrolled in an Health Maintenance Organization (HMO). MAC providers are reimbursed by Medicaid on a fee-for-service basis, while HMOs receive

capitated payments. Most of the school-based clinics are MAC providers.

Baltimore has successfully dealt with the issue of how to provide EPSDT services to children who are enrolled in a Medicaid HMO or linked to a MAC provider. If an HMO-enrolled child wants to receive EPSDT services at a school clinic, the clinic is required to obtain prior authorization from the HMO. The clinic then provides the EPSDT screening services, sends the results to the HMO, and is reimbursed by them for the amount that Medicaid would have paid for the services. For example, Total Health Care, an HMO with Medicaid clients in Baltimore, has a formal agreement with the school clinics authorizing the clinics to provide EPSDT services to Total Health Care members. If a child with a MAC provider wants to receive EPSDT services at a school clinic, the school must obtain a written referral from the MAC provider. The school is then able to bill Medicaid directly.

For additional information, please contact:
Bernice Rosenthal, M.P.H., Administrator
Baltimore City Health Department
410/396-3185

Hartford, Connecticut

Summary:

The Hartford school district provides screening and treatment services to students in school through clinics in 40 public schools in the city. The combination of school nurses and nurse practitioners used in the school clinic depends on the degree of need. The local Board of Education is enrolled as a Medicaid provider and bills for EPSDT and other Medicaid services provided to students.

Description:

In Hartford, Connecticut, all children have access to screening, diagnosis, and treatment services in school, including EPSDT services for Medicaid-eligible children. Approximately 65% of the 26,000 children in the school system are eligible for Medicaid.

The services are provided through fully licensed outpatient clinics in each of the 40 schools in the district. The clinics are staffed by a combination of school nurses and nurse practitioners that varies with the level of need in a particular school. Level of need is determined by the size of the school and the percentage of kids without a primary care physician or other medical home.

At the beginning of each school year, every child and family is notified of the availability of services and given a permission form which has to be signed before services will be provided. On the permission form the family is asked to indicate the availability of health insurance, including Medicaid. To protect a child's privacy, the child is not asked for insurance information at the clinic. Rather, this information is collected from the child's file.

Vision and hearing are tested annually, while screening and other services are provided periodically. For example, unclothed physical examinations are required before a child enters school, and are offered in the 6th and 10th grades. Dental services are available in six schools and four additional schools are developing dental services for next year. In the middle schools and high schools, students using the clinics are given a risk assessment and directed to needed support services. Mental health services are available in some schools, but there still exists a tremendous need for these services.

The local Board of Education is enrolled as a Medicaid provider and bills for services provided in schools in the district. Schools

submit an encounter form for each child's visit to the district central office which in turn bills Medicaid and other insurers. Children with no insurance are billed based on a sliding scale fee system.

Three years ago the school district implemented a computerized tracking system that contains utilization and referral information on each child. The referral information facilitates follow-up and helps the school monitor who is managing the child's care. The school district is developing a more intensive case management system for future implementation.

For additional information, please contact:
Leah Fichtner
Hartford Public School System
203/722-8966

Independence, Missouri

Summary:

In Independence, Missouri, EPSDT and other screening services are provided to all children. The school board is enrolled as a Medicaid provider and bills for the screening services and some treatment services.

Description:

In Independence, Missouri, screening services are available to children in schools through EPSDT and other programs. The services are available to all students, so Medicaid-eligible children are not singled out. Children from birth to age 5 also receive screening services through programs conducted at the school such as Head Start, Even Start, and child care.

Providers, who are predominantly physicians, conduct health screenings in a different school each month. The schools would like to hire nurse practitioners but have found it difficult to recruit the few that practice in the area. The local Board of Education itself is enrolled as a Medicaid provider, and bills for the screenings through a special contract with the department of social services. The school board also bills private insurers for covered services and has been doing this for years.

The screenings are targeted to those children most in need of services, particularly those without a permanent physician. School principals, counselors, and special education coordinators are all educated about the availability of services and refer students for screenings. The program is targeted toward improving health care for all children, especially low income children. While some services, such as speech therapy, occupational therapy, physical therapy, and psychological services, are provided in the schools, students are referred to community providers for the majority of diagnostic and treatment services. The school system runs an interagency center which facilitates referrals to these providers.

About 20-25 percent of the Medicaid-eligible students are enrolled in managed care programs. The school is not reimbursed for services provided to these students, but the school has worked out an agreement with the managed care providers to provide occupational therapy, physical therapy, and speech therapy.

For additional information, please contact:
Jim Caccamo
Assistant to the Superintendent
Independence School System
816/833-3433

Louisiana

Summary:

Almost one-half of the school boards in Louisiana are enrolled as Medicaid screening providers. In these districts, school nurses provide EPSDT screening services to eligible

children and refer them to community providers for diagnostic and treatment services. Most schools also provide health related special education services, such as physical therapy. In State Fiscal Year 1991, 21,000 children were screened. Louisiana Medicaid recently implemented its Kid-Med program, a coordinated care system for EPSDT. In addition, one of three rural primary care case management projects has an agreement with an elementary school to provide EPSDT screening services.

Description:

Since 1972, schools in Louisiana have conducted outreach and provided EPSDT screening services to children. Only Medicaid-eligible children are eligible for the screening services, but stigmatization is not a problem since they are the majority in many of the schools. Prior to 1990, 15 school boards enrolled as Medicaid providers and schools in their districts provided EPSDT screening services. The number of participating school boards dramatically increased after 1990 when the U.S. Department of Health and Human Services established the goal of 80% EPSDT participation by 1995. Currently 30 school boards in the state are enrolled as Medicaid screening providers and the numbers are continuing to increase. These schools were able to screen almost 21,000 children during State Fiscal Year 1991.

Schools employ school nurses, with consultation from physicians, to provide screening services in the schools. In Louisiana, nurses are authorized to do an unclothed physical so they are able to complete the full EPSDT screen. Nurses refer students in need of additional services to providers in the community. If they have difficulty finding a provider they may turn for assistance to the Kid-Med program, Louisiana's newly developed coordinated care system for EPSDT.

Louisiana Medicaid recently contracted with a private firm to administer Kid-Med. The contractor is responsible for outreach, provider recruitment, service coordination, screening administration, and monitoring the EPSDT program. As part of outreach, the Kid-Med program contacts Medicaid-eligible children and asks where they would like to be screened. If the child and family choose a school, Kid-Med notifies the school.

Since 1988, Louisiana schools have also been providing health related special education services to children with disabilities. Currently, sixty-five of the state's sixty-six local educational agencies provide these services which include: speech and language pathology, audiology, occupational therapy, physical therapy, and psychological evaluations and therapies.

Schools electronically bill Medicaid for services either with their own system or through a contractor; they also bill third parties when the child has coverage, which is rare. Schools must bill within 60 days so that follow-up is facilitated. Kid-Med receives screening, suspected condition, referral, and immunization information so they can track kids who were referred for diagnostic and treatment services.

Louisiana has three Medicaid primary care case management (PCCM) pilot projects, all of which are in rural areas. The PCCM providers can choose whether or not they want to authorize schools to provide EPSDT screens to their clients. In one pilot project area, the PCCM providers have worked out an agreement with an elementary school to conduct EPSDT screens.

For additional information, please contact:
Suzanne Danilson
EPSDT Coordinator
Louisiana Department of Health and Hospitals
504/342-3881

Philadelphia, Pennsylvania

Summary:

Philadelphia is one of the few cities to have physicians providing EPSDT services in schools. Physicians have established offices for EPSDT screening purposes in 78 Philadelphia schools. The physicians primarily serve children they have served before outside of school and are responsible for billing Medicaid themselves.

Description:

Unlike most school-based programs which use mid-level practitioners, such as nurse practitioners, physicians have provided EPSDT screening services in 78 Philadelphia schools for over five years.

The physicians establish an office at the school and primarily serve children they have served before outside school. The school office has to be approved by the state Medicaid office to ensure it is appropriate, private, and adequately equipped. Physicians bill Medicaid for their services using their own provider numbers. Providers are required to indicate where the service was rendered on the screening invoice so state officials can identify and monitor the services.

For additional information, please contact:
Don Yearsley
EPSDT Coordinator
Pennsylvania Department of Public Welfare
(717)782-6341

Pittsburgh, Pennsylvania

Summary:

In Pittsburgh, schools are enrolled as EPSDT providers and employ certified registered nurse practitioners to provide screening services on-site. The schools do not provide additional medical services. A private contractor handles billing for the schools and will assist with referrals for follow-up services when necessary. Medicaid-eligible children participating in HMOs are not authorized to receive screening services through the schools.

Description:

In Pittsburgh, all of the schools were enrolled as Medicaid providers in 1992 and authorized to provide EPSDT screening services on-site. This supplemented the EPSDT service delivery sites available through the private physician network. Each Medicaid-eligible child chooses where he or she would like to receive EPSDT screening services.

Certified registered nurse practitioners (CRNP) are employed by the schools only to provide EPSDT screening services to eligible children. Each CRNP serves several of the approximately 80 schools in the city.

EPSDT billing is provided through a State-administered administrative contractor. The contractor has an arrangement with the state to handle many of the EPSDT administrative responsibilities including provider outreach, billing, follow-up, and informing clients and providers when screenings are due. The local county assistance offices are responsible for informing children and families newly enrolled in Medicaid about the benefits and availability of EPSDT services.

There is one Medicaid HMO in Pittsburgh. Medicaid-eligible children enrolled in this HMO are not eligible for EPSDT screening

services through the schools since the HMO providers are paid on a capitated basis and are responsible for the EPSDT screen.

For additional information, please contact:
Don Yearsley
EPSDT Coordinator
Pennsylvania Department of Public Welfare
(717)782-6341C.

C. Comparison of Linkages

The purpose of this comparison is not to evaluate which program has a "better" arrangement, but to help schools think about alternative arrangements for working with the EPSDT program. The comparison is organized around the questions listed in the introduction to this chapter.

What services are provided in the school?

One of the biggest differences between programs is the type of services they offer at the school. At a minimum, schools can conduct outreach and publicize the EPSDT program and the importance of preventive care. Schools may also provide case management services for Medicaid-eligible children. In Baltimore, school nurses conduct case management, including outreach, appointment scheduling, transportation assistance, and follow-up for Medicaid-eligible students.

The most common EPSDT-related service that schools provide is screening. All of the programs described in this guide offer screening services, although to differing degrees. In Independence, the screening providers come into the schools approximately once a month. In Hartford, on the other hand, screening services are available throughout the school year. Some schools go one step further and provide limited treatment services as well. In Independence, speech therapy, occupational therapy, physical therapy, and psychological services are offered on-site. Finally, some schools support comprehensive school-based clinics which provide diagnostic and treatment services for conditions identified in the EPSDT screens. Baltimore has ten school-based clinics and Hartford has clinics in all forty schools.

What types of providers are used?

Schools use several types of providers for EPSDT services and in a variety of arrangements. For example, to conduct screenings, the Louisiana program uses school nurses, while Hartford uses nurse practitioners and Philadelphia and Independence use physicians. One of the reasons schools use different providers in different states is that in some states nurses are more limited in what services they are authorized to provide. For example, in Louisiana nurses are authorized by the State Nurse Practice Act to conduct unclothed physical examinations, while in other states they are prohibited from this activity and thus can not conduct a complete EPSDT screen.

Schools also use different arrangements for contracting with providers for services. In Louisiana and Hartford, the school nurses and nurse practitioners are employees of the schools; while in Philadelphia the physicians have an agreement to use space in the schools but are not employed by the school.

Who bills Medicaid for services?

The arrangement between schools and providers governs how and by whom Medicaid is billed for services. When the provider is employed by the school, the school is often enrolled as a Medicaid provider and bills for the service, as is done in Louisiana. Many schools contract with a third party to actually bill for the services using the

school's Medicaid provider number. If a provider furnishes services as an independent practitioner, the provider needs to be enrolled with Medicaid and bills for services, as in Philadelphia. Finally, if another institution, such as a community health center or a city health department, employs the staff that provides services at the schools, then that institution bills Medicaid. In Baltimore, the city health department runs eight school-based clinics and bills Medicaid for services.

To whom are services targeted?

Some programs target only Medicaid-eligible children while others serve all students. In Louisiana, only Medicaid-eligible children receive screening services. In other programs, EPSDT is one component of a school-wide health program. For example, in Independence and Hartford services are provided to all children and Medicaid is billed for only those services provided to eligible children. In Baltimore, a portion of school nurses' time is set aside specifically for EPSDT outreach and case management.

How will the school serve children in Medicaid coordinated, or managed, care arrangements?

For this guide, managed care is broadly defined as an arrangement among the State Medicaid agency, the Medicaid-eligible individual or recipient, and a provider whereby the individual's health care is limited to a certain provider or set of providers. The provider may be reimbursed based on a capitated rate (lump sum) as is done in a Health Maintenance Organization (HMO) or based on fee-for-service.

In the interviews for the examples in this chapter, many schools raised concerns about the impact of managed care on their ability to provide EPSDT to Medicaid-eligible students. Communities have had varying success in arranging for schools to provide EPSDT services to students enrolled in managed care, since schools may or may not be one of the authorized providers for the managed care organization. In Baltimore, schools can be reimbursed for services as long as they first obtain permission from a child's managed care provider. In one instance a formal agreement with an HMO provider authorizes the school to provide EPSDT services. The school is reimbursed by the managed care provider on a fee-for-service basis. Similarly, in Louisiana, a rural primary care case management project authorizes an elementary school to conduct EPSDT screens for its enrollees. Unlike in Baltimore, the school bills Medicaid directly for the services. Finally, in Pittsburgh, students enrolled in HMO managed care programs are not authorized to receive services in the school.

1. APPENDICES

A. Federal Regional Contacts:

- HCFA EPSDT Program Coordinators
- Department of Education Representitives
- PHS MCH Program Consultants

B. State Contacts:

- State Medicaid Directors and EPSDT Coordinators
- Chief State School Officers
- State MCH Directors

APPENDIX A

FEDERAL REGIONAL CONTACTS

Health Care Financing Administration, Public Health Service, and Education staffs are assigned to each of the ten regional offices of the Federal Department of Education and Federal Department of Health and Human Services. Medicaid, Education, and Maternal and Child Health program contacts for each region are listed below:

— Region I —

Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Ronald Preston
Associate Regional Administrator
HCFA, Division of Medicaid
JFK Federal Building, Rm. 2350
Boston, MA 02203
(617) 565-1223

Dennis Smith
Secretary's Regional Representative
Department of Education
540 McCormack Courthouse
Post Office Square
Boston, MA 02109-4557
(617) 223-9317

Gertrude Bramley, MD, MPH
Regional MCH Medical Consultant
Public Health Service
1401 John F. Kennedy Bldg.
Boston, MA 02203
(617) 565-1460

Arthur Mazer
HCFA MCH/EPSDT Specialist
(617) 565-1223

— Region II —

New Jersey, New York, Puerto Rico, Virgin Islands

Arthur J. O'Leary
Associate Regional Administrator
HCFA, Division of Medicaid
26 Federal Plaza
New York, NY 10278
(212) 264-2504

Herbert Stupp
Acting Secretary's Regional Representative
Department of Education
26 Federal Plaza, Rm 36-120
New York, NY 10278
(212) 264-7005

Margaret Lee, MD
Regional MCH Program Consultant
Public Health Service
26 Federal Plaza, Room 3337
New York, NY 10278
(212) 264-4628

Jane Salchli
HCFA MCH/EPSDT Specialist
(212) 264-2775

— Region III —

Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia

Robert J. Taylor
Associate Regional Administrator
HCFA, Division of Medicaid
3535 Market Street, Rm. 3100
P.O. Box 7760
Philadelphia, PA 19101
(215) 596-1378

D. Kay Wright
Secretary's Regional Representative
Department of Education
3535 Market Street, Room 16350
Philadelphia, PA 19104
(215) 596-1001

Frank Heron, M.D.
Regional MCH Program Consultant
Public Health Service
P.O. Box 13716
Philadelphia, PA 19101
(215) 596-6686

Betty Wheeler
HCFA MCH/EPSDT Specialist
(215) 596-0634

— Region IV —

Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee

William R. Lyons
Associate Regional Administrator
HCFA, Division of Medicaid
Suite 602
101 Marietta Street
Atlanta, GA 30323
(404) 331-2418

Anne Hancock
Acting Secretary's Regional Representative
Department of Education
P.O. Box 1777
101 Marietta Tower Building
Suite 2221
Atlanta, GA 30323
(404) 331-2502

Ketty M. Gonzalez, MD
Chief, Family Health Branch
Division of Family Health & Resources Development
Public Health Service
101 Marietta Tower, NW
Atlanta, GA 30323
(404) 331-5394

Cathy Kasriel
HCFA MCH/EPSDT Specialist
(404) 331-5028

— Region V —

Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin

Charles W. Hazlett
Associate Regional Administrator
HCFA, Division of Medicaid, 15th Floor
105 West Adams Street
Chicago, IL 60603-6201
(312) 886-5354

Brian Carey
Secretary's Regional Representative
Department of Education
401 South State Street
Suite 700A
Chicago, IL 60605
(312) 353-5215

Kathryn Vedder, MD, MPH
Chief, MCH
Family Planning Services Branch
Public Health Service
105 West Adams
Chicago, IL 60603
(312) 353-1700

Barbara England
HCFA MCH/EPSDT Specialist
(312) 353-8720

— Region VI —

Arkansas, Louisiana, New Mexico, Oklahoma, Texas

James Reed
Associate Regional Administrator
HCFA, Division of Medicaid
1200 Main Tower Building, Room 2030
Dallas, TX 75202
(214) 767-6493

Sam P. Wilson
Secretary's Regional Representative
Department of Education
1200 Main Tower Building, Room 2125
Dallas, TX 75202
(214) 767-3626

Gene Sterritt, DDS, MPH
Chief, MCH/Family Planning Branch
Public Health Service
1200 Main Tower Building
Dallas, TX 75202
(214) 767-3072

Carl Silvernail
HCFA MCH/EPSDT Specialist
(214) 767-3693

— Region VII —

Iowa, Kansas, Missouri, Nebraska

Richard P. Brummel
Associate Regional Administrator
HCFA, Division of Medicaid
Room 235 New Federal Office Bldg.
601 East 12th Street
Kansas City, MO 64106
(816) 426-5925

Cynthia A. Harris Hillman
Secretary's Regional Representative
Department of Education
10220 N. Executive Hills Blvd.
9th Floor
Kansas City, MO 64153-1367
(816) 891-7972

Bradley E. Appelbaum, MD, MPH
Regional MCH Program Consultant
Public Health Service
601 E. 12th Street, Room 501
Kansas City, MO 64106
(816) 426-2924

Bonnie Bailey-Howard
HCFA MCH/EPSDT Specialist
(816) 426-3406

— Region VIII —

Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming

Gary Wilks
Associate Regional Administrator
HCFA, Division of Medicaid
Room 576 Federal Office Building
1961 Stout Street
Denver, CO 80294
(303) 844-2121 Ext. 352

Thomas Tancredo
Secretary's Regional Representative
Department of Education
Regional Office, Federal Building
1244 Speer Boulevard, Suite 310
Denver, CO 80204-3582
(303) 844-3544

Joan E. Carter, MPH
Acting MCH Program Consultant
Public Health Service, DHHS
Federal Building, Room 1994
1961 Stout Street
Denver, CO 80294
(303) 844-5955

Charles Crosley
Chief, Medicaid Operations Branch, HCFA
(303) 844-6216, Ext. 355

— Region IX —

American Samoa, Arizona, California, Guam, Hawaii, Nevada, Northern Marianas Islands

Lawrence L. McDonough
Associate Regional Administrator
HCFA, Division of Medicaid
4th Floor
75 Hawthorne Street
San Francisco, CA 94105
(415) 744-3568

John McCarthy
Secretary's Regional Representative
Department of Education
50 United Nations Plaza, Room 205
San Francisco, CA 94102
(415) 556-4920

Reginald Louie, DDS
Public Health Service
50 United Nations Plaza
San Francisco, CA 94102
(415) 556-5581

Edna Ray
HCFA MCH/EPSDT Specialist
(415) 744-3598

— Region X —

Alaska, Idaho, Oregon, Washington

Thomas G. Wallner
Associate Regional Administrator
HCFA, Division of Medicaid
Mail Stop RX-43
2201 Sixth Avenue
Seattle, WA 98121
(206) 553-7806

Roberta May
Secretary's Regional Representative
Department of Education
Jackson Federal Building
915 2nd Avenue, Rm 3362
Seattle, WA 98174-1099
(206) 553-0460

David R. Hutchinson
MCH Division Director
Public Health Service, DHHS
2201 Sixth Avenue, MS RX-27
Seattle, WA 98121
(206) 553-0215

Helen Phillips
HCFA MCH/EPSDT Specialist
(206) 553-0587

APPENDIX B

STATE CONTACTS

The following State and Territorial contacts are listed:

- State Medicaid Director and EPSDT Coordinator
- Chief State School Officer
- State Maternal and Child Health Director
- State Coordinator for Children with Disabilities

*In some States and Territories, these may be listed under an umbrella contact (e.g. State health director).

— ALABAMA —

Brian W. Moore
Commissioner
Alabama Medicaid Agency
2500 Fairlane Drive
Montgomery, AL 36110
(205) 277-2710

Wayne Teague
Superintendent of Education
State Department of Education
Gordon Persons Office Building
50 North Ripley Street
Montgomery, AL 36130-3901
(205) 242-9700

Lawrence Gulley
Director
Bureau of Family Health Serv.
Alabama Dept. of Public Health
434 Monroe Street, Room 381
Montgomery, AL 36130-1701
(205) 242-5052

Kay Herrin, MSW
Assistant Director
Division of Rehab. and Crippled Children's Services
2129 East South Boulevard
Montgomery, AL 36111-0586
(205) 281-8780

Laura McHenry
EPSDT Coordinator

— ALASKA —

Kim Busch
Director
Division of Medical Assistance
Department of Health and Social Services
P.O. Box H
Juneau, AK 99811-0660
(907) 465-3388

Gerald Covey
Commissioner of Education
State Department of Education
801 W. 10th St. Suite 200
Juneau, AK 99801-1894
(907) 465-2800

Karen Pearson, RD, MS
Chief
Section of Maternal, Child, & Family Health
Alaska Dept. of Health and Social Services
1231 Gambell St., Rm. 311
Anchorage, AK 99501-4627
(907) 274-7626

Linda Vlastuin, RN
Handicapped Children's Program
Alaska Dept. of Health and Social Services
1231 Gambell
Anchorage, AK 99501-4627
(907) 274-7626

Linda Cameron, RN
EPSDT Coordinator

— American Samoa —

Charles R. McCuddin
Medicaid Coordinator
LBJ Tropical Center
Pago Pago, AS 96799
(011) 684-633-4559

Lealofi Uiagalelei
Director of Education
Department of Education
Pago Pago, AS 96799
(011) 684-633-5237

Iotamo Saleapaga, MD
Director, Dept. of Health
Pago Pago, AS 96799
(011) 684-633-1222

— Arizona —

Leonard J. Kirschner, M.D.,
MPH Director
Arizona Health Care Cost Containment System (AHCCCS)
801 East Jefferson
Phoenix, AZ 85034
(602) 234-3655

C. Diane Bishop
Superintendent of Public Instruction
State Department of Education
1535 West Jefferson
Phoenix, AZ 85007
(602) 542-4361

Jane Pearson, RN, Chief
Office of MCH, Div. of Family Health Services
Arizona Dept. of Health
1740 West Adams Street
Phoenix, AZ 85007
(602) 542-1870

Juman Abujbara, M.D.
EPSDT Coordinator

— Arkansas —

Ray Hanley
Director
Office of Medical Services
Department of Human Services
P.O. Box 1437
Little Rock, AR 72203-1437
(501) 682-8292

Burton Elliott
Director, General Education Division
State Department of Education
Four State Capitol Mall, Room 304A
Little Rock, AR 72201-1071
(501) 682-4204

Donnie Smith, Director
Div. of MCH
Arkansas Dept. of Health
4815 West Markham
Little Rock, AR 72201
(501) 661-2251

Nancy Church, RN
Administrator
Children's Medical Services
Dept. of Human Serv.
P.O. Box 1437
Little Rock, AR 72203
(501) 682-2277

Carlene Peterson
EPSDT Coordinator

— California —

Jose Fernandez
Deputy Director
Medical Care Services
Department of Health Services
714 P Street, Room 1253
Sacramento, CA 95814
(916) 657-1496

Bill Honig
Superintendent of Public Instruction
State Department of Education
721 Capitol Mall
Sacramento, CA 95814
(916) 657-5485

Rugmini Shah, MD
Chief, MCH Branch
Div. of Family Health Services
State Dept. of Health
Room 750
714 P Street
Sacramento, CA 95814
(916) 323-8181

California (contd)

Maridee Gregory, MD
Chief, Calif. Children's Serv.
State Dept. of Health
Room 323
714 P Street
Sacramento, CA 94234-7320
(916) 322-2090

Janet Toney
EPSDT Coordinator

— Colorado —

David West, Ph.D.
Director
Bureau of Medical Services
Department of Social Services
1575 Sherman Street
Denver, CO 80203-1714
(303) 866-5901532

William T. Randall
Commissioner of Education
State Department of Education
201 East Colfax Avenue
Denver, CO 80203-1705
(303) 866-6806

Robert S. McCurdy, MD, MPH
Director
Medical Affairs/Special Programs
Colorado Dept. of Health
4210 East 11th Avenue
Denver, CO 80220
(303) 331-8373

Sue Dunn, MSW
Director
Handicapped Children's Program
Colorado Dept. of Health
4210 East 11th Avenue
Denver, CO 80220
(303) 331-8404

Mary Fournier
EPSDT Coordinator

— Connecticut —

Linda Schofield
Director
Medical Care Administration
Department of Income Maintenance
110 Bartholomew Avenue
Hartford, CT 06106
(203) 566-2934

Vincent L. Ferrandino
Commissioner of Education
State Department of Education
165 Capitol Avenue
Room 305, State Office Building
Hartford, CT 06106
(203) 566-5061

Jadwiga Goclowski, RN, PhD
Director, Div. of MCH
Bureau of Community Health
150 Washington Street
Hartford, CT 06106
(203) 566-5601

Nancy Zinneman Berger, MPH
Director, Div. of Children with Special Health Needs
Bureau of Community Health
150 Washington Street
Hartford, CT 06106
(203) 566-2057

Donna Moore
EPSDT Coordinator

— Delaware —

Philip Soule, Sr.
Medicaid Director
Division of Social Services
Department of Health and Social Services
1901 North DuPont Highway
New Castle, DE 19720
(302) 577-4901

Pascal D. Forgione
Superintendent of Public Instruction
State Department of Public Instruction
P.O. Box 1402-Townsend Bldg., #279
Federal & Lockerman Streets
Dover, DE 19903
(302) 739-4601

Deborah Clendaniel
Director, MCH Services
Div. of Public Health
Jesse S. Cooper Memorial Bldg.
P.O. Box 637
Dover, DE 19903
(302) 736-4785

Sathyavathi Lingaraju, MD, MPH
Director, Child Health/CSHN
Div. of Public Health
P.O. Box 637
Dover, DE 19903
(302) 736-4786

Sandy Trotter
EPSDT Coordinator

— District of Columbia —

David Coronado
Commissioner
Commission on Health Care Financing
Department of Human Services
Suite 302
2100 Martin Luther King, Jr. Ave., SE
Washington, DC 20023
(202) 727-0735

Franklin L. Smith
Superintendent of Public Schools
District of Columbia Public Schools
415 12th Street, NW
Washington, DC 20004
(202) 724-4222

Harry C. Lynch, MD
Chief, Bureau of MCH
Dept. of Human Services
1660 L Street, NW
Suite 904
Washington, DC 20036
(202) 673-6665

C.J. Wellington, MD
Director
Handicapped Children's Unit
D.C. General Hospital, Bldg. 10
19th and Massachusetts Ave., SE
Washington, DC 20003
(202) 675-5214

Sara Davidson
EPSDT Coordinator

— Florida —

Gary J. Clarke
Assistant Secretary, Medicaid
Department of Health and
Rehabilitation Services
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
(904) 488-3560

Betty Castor
Commissioner of Education
State Department of Education
Capitol Building, Room PL 08
Tallahassee, FL 32301
(904) 487-1785

Donna Barber, RN, MPH
Chief
Health Program Policy & Devel.
Dept. of Health/Rehab Services
Family Health Services
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
(904) 487-1321

J. Michael Cupoli, MD
Director
Children's Medical Serv. Program
Dept. of Health/Rehab Services
Building 5, Room 127
1323 Winewood Boulevard
Tallahassee, FL 32301
(904) 487-2690

Anne Boone
EPSDT Coordinator

— Georgia —

Russell B. Toal
Commissioner
Department of Medical Assistance
2 Martin Luther King, Jr., Drive, SE
1220-C West Tower
Atlanta, GA 30334
(404) 656-4479

Werner Rogers
Superintendent of Schools
State Department of Education
2066 Twin Towers East
205 Butler Street
Atlanta, GA 30334
(404) 656-2800

Georgia (contd)

Virginia D. Floyd, MD
Director
Family Health Serv. Section
Georgia Dept of Human Resources
Div of Public health
878 Peachtree Street, NE, Suite 217
Atlanta, GA 30309
(404) 894-6622

Lynette Jackson Hunt, MD, MPH
Chief, Children's Health Serv.
Georgia Dept of Human Resources
2600 Skyland Drive (lower level)
Atlanta, GA 30319
(404) 320-0529

Cindy Barton
EPSDT Coordinator

— Guam —

Adoracion Solidnum
Administrator
Bureau of Health Financing
Dept. of Public Health and Social Services
P.O. Box 2816
Agana, GU 96910
(011) 671-734-7269

Franklin J.A. Quitugua
Director of Education
Department of Education
P.O. Box DE
Agana, GU 96910
(011) 671-472-8901

Leticia V. Espaldon, MD
Director, Dept. of Public Hlth and Social services
P.O. Box 2816
Agana, GU 96910
(011) 671-734-2083

John Leon Guerrero
EPSDT Coordinator

— Hawaii —

Winifred Odo
Administrator
Health Care Admin. Div.
Dept. of Human Services
P.O. Box 339
Honolulu, HI 96809
(808) 586-5392

Hawaii (contd)

Charles Toguchi
Superintendent of Education
Department of Education
1390 Miller Street, #307
Honolulu, HI 96804
(808) 586-3230

Loretta Fuddy, ACSW, MPH
MCH Branch
Hawaii Dept. of Health
741-A Sunset Avenue
Honolulu, HI 96816
(808) 737-8229

Alan Taniguchi, MD
Chief, Children with Special Hlth Care Needs Branch
Hawaii Dept of Health
741 Sunset Avenue
Honolulu, HI 96816
(808) 732-3197

Cynthia Nishimura
EPSDT Coordinator

— Idaho —

Jan Cheever
Acting Chief
Bureau of Medicaid Policy and Reimbursement
Dept. of Health and Welfare
450 West State Street
Boise, ID 83720-5450
(208) 334-5795

Jerry L. Evans
Superintendent of Public Instruction
State Department of Education
Len B. Jordan Office Building
650 West State Street
Boise, ID 83720
(208) 334-3300

Jane Smith
Chief, Bureau of MCH
Idaho Dept of Health/Welfare
450 West State Street
Boise, ID 83720
(208) 334-5965

Carol Hesse, MSW
Program Manager
Children with Special Health Needs Program
Bureau of MCH
Idaho Dept of Health/Welfare
450 West State Street
(208) 334-5963

Idaho (contd)

Kay Youngerman, R.N.
EPSDT Coordinator

— Illinois —

Theresa Stoica
Deputy Director Medical Operations
Illinois Department of Public Aid
201 South Grand Avenue, East
Springfield, IL 62743-0001
(217) 782-2570

Robert Leininger
Superintendent of Education
State Board of Education
100 North First Street
Springfield, IL 62777
(217) 782-2221

Stephen E. Saunders, MD, MPH
Chief, Div of Family Health
Illinois Dept of Public Health
535 West Jefferson Street
Springfield, IL 62761
(217) 782-2736

Robert Biehl, MD
Director, Div of Specialized Care for Children
Univ. of Illinois at Chicago
2815 West Washington, Suite 300
P.O. Box 19481
Springfield, IL 62794-9481
(217) 793-2340

Debby Saunders
EPSDT Coordinator

— Indiana —

James M. Verdier
Assistant Secretary Medicaid Policy and Planning
Indiana Family and Social Services Administration
402 West Washington Street, Rm 402
P.O. Box 7083
Indianapolis, IN 46207-7083
(317) 233-4455

H. Dean Evans
Superintendent of Public Instruction
State Department of Education
State House, Room 229
Indianapolis, IN 46204-2798
(317) 232-6665

Indiana (contd)

Judith Ganser, MD
Director
Div of MCH Services
Indiana Dept. of Health
1330 W. Michigan Street
P.O. Box 1964
Indianapolis, IN 46206-1964
(317) 633-8478

James K. Ladd, MS
Director, Children's Special Hlth Care Serv Div
Indiana State Dept. of Health
1330 W. Michigan Street
P.O. Box 1964
Indianapolis, IN 46206-1964
(317) 633-8522

Ivan Sumner
EPSDT Coordinator

— Iowa —

Donald Herman
Administrator
Division of Medical Services
Department of Human Services
Hoover State Office Building
Des Moines, IA 50319
(515) 281-8794

William L. Lepley
Director of Education
State Department of Education
Grimes State Office Building
East 14th & Grand Streets
Des Moines, IA 50319-0146
(515) 281-5294

Joyce Borgmeyer, MS
Chief, Bureau of Family Serv
Div of Family/Community Hlth
Iowa Dept of Public Health
Lucas State Office Building
Des Moines, IA 50319
(515) 281-4911

Richard P. Nelson, MD
Director, Iowa Child Health
Specialty Clinic
University of Iowa
Iowa City, IA 52242
(319) 356-1118

Joe Mahrenholz
EPSDT Coordinator

— KANSAS —

Joyce Sugrue, R.N.
Director
Medical Services
Dept. of Social and Rehab Services
Docking State Office Building
Topeka, KS 66612
(913) 296-3981

Lee Droegemueller
Commissioner of Education
State Department of Education
120 South East Tenth Street
Topeka, KS 66612
(913) 296-3202

Linda Kenney, MPH
Acting Director
Bureau of Family Health
Kansas Dept of Hlth & Environ.
Landon State Office Building
900 SW Jackson, 10th Floor
Topeka, KS 66612-1290
(913) 296-1303

Cassie Lauver, ACSW
Director, Services for Children with Special Health Care Needs
Kansas Dept of Hlth & Environ.
900 SW Jackson, 10th Floor
Topeka, KS 66612-1290
(913) 296-1313

Emily Russell
EPSDT Coordinator

— KENTUCKY —

Roy Butler
Commissioner
Department of Medicaid Services
275 East Main Street
Frankfort, KY 40621
(502) 564-4321

Thomas C. Boysen
Commissioner of Education
State Department of Education
Capitol Plaza Tower - 500 Mero Street
Frankfort, KY 40601
(502) 564-4770

Patricia K. Nicol, MD, MPH
Director, Division of MCH
Kentucky Dept of Human Resources
275 East Main Street
Frankfort, KY 40621
(502) 564-4830

Kentucky (contd)

Harry G. Dickerson
Executive Director
Commission for Handicapped Children
Kentucky Dept of Human Resources
1405 East Burnett Avenue
Louisville, KY 40217
(502) 588-3264

Betty Weaver
EPSDT Coordinator

— LOUISIANA —

John L. Futrell
Director
Bureau of Health Services Financing
P.O. Box 91030
Baton Rouge, LA 70821-9030
(504) 342-3891

Raymond G. Arveson
Superintendent of Education
State Department of Education
P.O. Box 94064
626 North 4th Street
Baton Rouge, LA 70804-9064
(504) 342-3602

Joan Wightkin, MPH
Acting Administrator
MCH Section
Dept. of Health & Hospitals
P.O. Box 60630
New Orleans, LA 70160
(504) 568-5073

David Thomas
Administrator
Handicapped Children's Services
Office of Public Health
Dept. of Health & Hospitals
P.O. Box 60630
New Orleans, LA 70160
(504) 568-5055

Suzanne Danilson
EPSDT Coordinator

— MAINE —

Elaine Fuller
Director
Bureau of Medical Services
Department of Human Services
State House, Station 11
Augusta, ME 04333
(207) 289-2674

Maine (contd)

Mary S. Ward
(Interim) Commissioner of Education
Maine Dept. of Education
State House Station #23
Augusta, ME 04333
(207) 289-5800

Zsolt Koppanyi, MD, MPH
Director
Division of MCH
Maine Dept of Human Services
State House Station 11
151 Capitol Street
Augusta, ME 04333
(207) 289-3311

Kathleen Burden
Director, Coordinated Care Serv for Children with Spec. Hlth Needs
State House Station 11
151 Capitol Street
Augusta, ME 04333
(207) 289-3311

Edna Jones
EPSDT Coordinator

— MARYLAND —

Nelson Sabatini
Acting Deputy Secretary
Health Care Policy, Finance, and Regulation
Room 500
201 West Preston Street
Baltimore, MD 21201
(301) 225-6505

Nancy S. Grasmick
Superintendent of Schools
State Department of Education
200 West Baltimore Street
Baltimore, MD 21201
(301) 333-2200

Polly Harrison, MD
Director
Child & Adolescent Health
Dept of Health/Mental Hygiene
201 W Preston Street
Baltimore, MD 21201
(301) 225-6749

Maryland (contd)

Judson Force, MD, MPH
Chief
Division of CCS
Dept of Health/Mental Hygiene
Mental Retardation/D D Admin
201 W Preston Street, 4th Floor
Baltimore, MD 21201
(301) 225-5580

Rose Ann Meinecke
EPSDT Coordinator

— MASSACHUSETTS —

Bruce M. Bullen
Deputy Commissioner, Medical Services
Department of Public Welfare
600 Washington Street
Boston, MA 02111
(617) 348-5691

Robert V. Antonucci
Commissioner of Education
State Department of Education
Quincy Center Plaza
1385 Hancock Street
Quincy, MA 02169
(617) 770-7321

Deborah Klein Walker, EdD
Assistant Commissioner
Bureau of Parent/Child/Adol Hlth
Mass. Dept of Public Health
150 Tremont Street, 4th Floor
Boston, MA 02111
(617) 727-3372

Deborah Allen, Ph.D.
Director
Division for CSHN
Bureau of Parent/Child/Adol Hlth
Mass. Dept of Public Health
150 Tremont Street, 7th Floor
Boston, MA 02111
(617) 727-6941

Karen Edlund
EPSDT Coordinator

— MICHIGAN —

Vernon K. Smith, Ph.D.
Director
Medical Services Administration
Department of Social Services
P.O. Box 30037
Lansing, MI 48909
(517) 335-5001

Robert E. Schiller
Superintendent of Public Instruction
State Department of Education
P.O. Box 30008
608 West Allegan Street
Lansing, MI 48909
(517) 373-3354

Denise Holmes, MS
Chief, Bureau of Comm. Serv.
Mich. Dept of Public Health
3500 North Logan Street
P.O. Box 30195
Lansing, MI 48909
(517) 335-8955

Janet Olszewski
Acting Chief
Children's Special Hlth Care Serv.
Bureau of Comm. Services
Mich. Dept of Public Health
3500 North Logan Street
P.O. Box 30195
Lansing, MI 48909
(517) 335-8961

William Keller, Ph.D.
EPSDT Coordinator

— MINNESOTA —

Robert Baird
Deputy Assistant Commissioner
Health Care Administration
Dept of Human Services
444 Lafayette Road
St Paul, MN 55155-3848
(612) 296-2766

Gene Mammenga
Commissioner of Education
State Department of Education
550 Cedar Street
St. Paul, MN 55101
(612) 296-2358

Minnesota (contd)

Pati Maier
Acting Director
Div of MCH
Minn. Dept of Health
717 Delaware Street, SE
P.O. Box 9441
Minneapolis, MN 55440
(612) 623-5166

Mary Kay Haas
EPSDT Coordinator

— MISSISSIPPI —

Helen Wetherbee
Executive Director
Division of Medicaid
Office of the Governor
239 North Lamar Street
Jackson, MS 39201-1399
(601) 359-6050

Tom Burnham
Superintendent of Education
State Department of Education
P.O. Box 771
550 High Street, Room 501
Jackson, MS 39205-0771
(601) 359-3513

William H. Sorey, MD
Chief
Bureau of Health Services
MS Department of Health
2423 North State Street
Jackson, MS 39215-1700
(601) 960-7463

Sam Valentine
Director
Children's Medical Program
MS Department of Health
P.O. Box 1700
Jackson, MS 39205-1700
(601) 987-3965

Jeanette Salk
EPSDT Coordinator

— Missouri —

Donna Chekett
Director
Division of Medical Services
Dept. of Social Services
P.O. Box 6500
Jefferson City, MO 65102
(314) 751-6922

Robert E. Bartman
Commissioner of Education
Dept. of Elementary & Secondary Education
P.O. Box 480
205 Jefferson Street, 6th Floor
Jefferson City, MO 65102
(314) 751-4446

Lorna Wilson, RN, MSPH
Director
Div of Maternal, Child, and Family Health
Missouri Dept of Health
1738 E Elm Street
P.O. Box 570
Jefferson City, MO 65102
(314) 751-6174

Helen Clarkston
EPSDT Coordinator

— Montana —

Nancy Ellery
Administrator
Medical Services Division
Department of Social and
Rehabilitation Services
P.O. Box 4210
Helena, MT 59604
(406) 444-4540

Nancy Keenan
Superintendent of Public Instruction
State Office of Public Instruction
106 State Capitol
Helena, MT 59620
(406) 444-3680

Maxine Ferguson, RN, MN
Bureau Chief
Family & MCH Bureau
MT Dept of Health & Environ. Sciences
Cogswell Building
Helena, MT 59620
(406) 444-4740

Nita Freeman
EPSDT Coordinator

— Nebraska —

Robert Seiffert
Administrator
Medical Services Division
Department of Social Services
301 Centennial Mall South, 5th Fl.
Lincoln, NE 68509
(402) 471-9147

Joseph E. Lutjeharms
Commissioner of Education
State Department of Education
P.O. Box 94987
301 Centennial Mall, South
Lincoln, NE 68509
(402) 471-5020

David P. Schor, MD
Director, Div of MCH
Nebraska Dept of Health
301 Centennial Mall South, 3rd Fl
P.O. Box 95007
Lincoln, NE 68509-5007
(402) 471-2907

Mary Jo Iwan
Administrator
Special Services for Children & Adults
Nebraska Dept of Social Serv
301 Centennial Mall South, 5th Fl
Lincoln, NE 68509-5026
(402) 471-9345

Sandi Kahlandt
EPSDT Coordinator

— Nevada —

April Hess
Deputy Administrator
Medicaid, Welfare Division
Department of Human Resources
2527 North Carson Street
Carson City, NV 89710
(702) 687-4378

Eugene T. Paslov
Superintendent of Public Instruction
State Department of Education
400 West King Street
Capitol Complex
Carson City, NV 89710
(702) 687-3100

Nevada (contd)

Yvonne Wimett
Manager, MCH/CSHCS
Nevada State Health Div
Room 205
505 East King Street
Carson City, NV 89710
(702) 687-4885

Marti Searcy, R.N.
EPSDT Coordinator

— New Hampshire —

Lee Bezanson
Acting Administrator
Office of Medical Services
Division of Human Services
6 Hazen Drive
Concord, NH 03301-6521
(603) 271-4314

Charles H. Marston
Commissioner of Education
State Department of Education
101 Pleasant Street
State Office Park South
Concord, NH 03301
(603) 271-3144

Charles Albano
Chief, Bureau of MCH
NH Div of Public Hlth Serv
6 Hazen Drive
Concord, NH 03301-6527
(603) 271-4516

Jane Hybsch, RN
Chief, Bureau of Special Medical Services
NH Div of Public Hlth Serv
6 Hazen Drive
Concord, NH 03301-6527
(603) 271-4596

Barbara Lamarre
EPSDT Coordinator

— New Jersey —

Saul Kilstein
Director
Division of Medical Assistance
and Health Services
Department of Human Services
CN-712, 7 Quakerbridge Plaza
Trenton, NJ 08625
(609) 588-2600

New Jersey (contd)

John Ellis
Commissioner of Education
State Department of Education
225 West State Street, CN500
Trenton, NJ 08625-0500
(609) 292-4450

George Halpin, MD
Director
Parental & Child Hlth Serv
NJ Dept of Health
CN 364
363 W. State Street
Trenton, NJ 08625-0360
(609) 292-5656

Barbara Kern, MA
Chief, Special Child Health Services Program
NJ Department of Health
CN 364
363 W. State Street
Trenton, NJ 08625-0364
(609) 292-5676

Danuta Buzdygan, M.D.
EPSDT Coordinator

— New Mexico —

Bruce Weydemeyer
Director
Medical Assistance Division
Human Services Dept.
P.O. Box 2348
Santa Fe, NM 87504-2348
(505) 827-4315

Alan D. Morgan
Superintendent of Public Instruction
State Department of Education Bldg.
300 Don Gaspar
Santa Fe, NM 87501-2786
(505) 827-6516

Ann Taulbee, MBA
Chief, Bureau of MCH
Dept of Health & Environ
1190 St. Francis Drive
P.O. Box 968
Santa Fe, NM 87504-0968
(505) 827-2350

New Mexico (contd)

Marilyn Sakara, MSW
Program Manager
Children's Medical Services
Dept of Health & Environ
P.O. Box 968
Santa Fe, NM 87504-0968
(505) 827-2350

Dale McManus
EPSDT Coordinator

— New York —

Jo-Ann Costantino
Deputy Commissioner
Division of Medical Assistance
Department of Social Services
40 North Pearl Street
Albany, NY 12243-0001
(518) 474-9132

Thomas Sobol
Commissioner of Education
State Education Department
111 Education Building
Washington Avenue
Albany, NY 12234
(518) 474-5844

Michael Cohen, MD
Director
Bureau of Child/Adol Hlth
NY Dept of Health
Corning Tower Bldg, Rm 780
Empire State Plaza
Albany, NY 12237
(518) 474-2084

Barbara Frankel
EPSDT Coordinator

— North Carolina —

Barbara Matula
Director
Division of Medical Assistance
Department of Human Resources
1985 Umstead Drive
P.O. Box 29529
Raleigh, NC 27626-0529
(919) 733-2060

Bob R. Etheridge
Superintendent of Public Instruction
State Department of Public Instruction
116 West Edenton Street
Raleigh, NC 27603-1712
(919) 733-3813

Ann Wolfe, MD
Director, Div of MCH
NC Dept of Environ., Health, and Natural Resources
P.O. Box 27687
Raleigh, NC 27611-7687
(919) 733-3816

Thomas Vitaglione, MPH
Chief, Children and Youth Sect.
NC Dept of Environ, Health, and Natural Resources
P.O. Box 27687
Raleigh, NC 27611-7687
(919) 733-7437

Sandra Cianciola
EPSDT Coordinator

— North Dakota —

Betty Strecker
Director
Medicaid Operations
Deptartment of Human Services
State Capitol-Judicial Wing
Bismarck, ND 58505-0261
(701) 224-2321

Wayne G. Sanstead
Superintendent of Public Instruction
State Dept. of Public Instruction
State Capitol Building, 11th Floor
600 Boulevard Ave. East
Bismarck, ND 58505-0440
(701) 224-2261

David Cunningham
Director, Div of MCH
ND Dept of Health
State Capitol Building
600 East Boulevard Ave
Bismarck, ND 58505
(701) 224-2493

Robert Nelson, MSW
Administrator
Crippled Children's Services
ND Dept of Human Services
State Capitol Bldg
600 E. Boulevard Ave
Bismarck, ND 58505-0269
(701) 224-2436

Camille Eisenmann
ESPDT Coordinator

— Northern Mariana Islands —

Maria A, V. Leon Guerrero
Medicaid Administrator
Deparment of Public Health and
Environment Services
Commonwealth of the Northern
Mariana Islands
P.O. Box 409 CK
Saipan, MP 96950
(011) 670-234-8950, ext. 2905

William S. Torres
Commissioner of Education
Department of Education
P.O. Box 1370 CK
Saipan, MP 96950
(011) 670-322-6451

Jose L. Chong
Director
Dept. of Public Health and Environment Serv.
Commonwealth of the Northern
Mariana Islands
Saipan, MP 96950
(011) 670-234-8950

— Ohio —

Kathryn T. Glynn
Director
Medicaid Administration
Department of Human Services
30 East Broad Street, 31st Fl.
Columbus, OH 43266-0423
(614) 644-0140

Ted Sanders
Superintendent of Public Instruction
State Dept. of Education
65 South Front Street, Room 808
Columbus, OH 43266-0308
(614) 466-3304

James F. Quilty, Jr., MD
Chief, Div of MCH
Ohio Dept of Health
246 North High street
P.O. Box 118
Columbus, OH 43266-0118
(614) 466-3263

Dinah Williams
EPSDT Coordinator

— Oklahoma —

Charles Brodt
Administrator
Division of Medical Services
Department of Human Services
P.O. Box 25352
Oklahoma City, OK 73125
(405) 557-2539

Sandy Garrett
Superintendent of Public Instruction
Secretary of Education
State Department of Education
Hodge Education Bldg.
2500 North Lincoln Boulevard
Oklahoma City, OK 73105-4599
(405) 521-3301

Sara Reed DePersio, MD, MPH
Medical Director
MCH Services
State Dept of Health
Room 703
1000 NE 10th Street
Oklahoma City, OK 73152
(405) 271-4476

Donna Huckleberry
EPSDT Coordinator

— OREGON —

Jean I. Thorne
Director
Office of Medical Assistance Programs
Department of Human Resources
203 Public Service Building
Salem, OR 97310
(503) 378-2263

Norma Paulus
Superintendent of Public Instruction
State Dept. of Education
700 Pringle Parkway, S.E.
Salem, OR 97310
(503) 378-3573

Donna Clark, RN
Assistant Administrator
Office of Health Services
Oregon State Health Division
800 NE Oregon, #21
Portland, OR 99201
(503) 229-6381

Victor D. Menashe, MD
Acting Director
Child Devel./Rehab Center
Oregon Health Sciences Univ.
P.O. Box 574
Portland, OR 99207
(503)494-8362

Bob Labbe
EPSDT Coordinator

— PENNSYLVANIA —

Sherry Knowlton
Deputy Secrtary for Medical Assistance
Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105-2675
(717) 787-1870

Donald M. Carroll, Jr.
Secretary of Education
State Dept. of Education
333 Market Street, 10th floor
Harrisburg, PA 17126-0333
(717) 787-5820

Judy Gallagher, MPH, MSN
Director, Div of MCH
Penna. Dept of Health
Health & Welfare Bldg
P.O. Box 90, Rm 725
Harrisburg, PA 17108
(717) 787-7192

Director
Div of Rehabilitative Serv
Penna. Dept of Health
Health & Welfare Bldg
P.O. Box 90, Room 714
Harrisburg, PA 17108
(717) 783-5436

Don Yearsley
EPSDT Coordinator

— PUERTO RICO —

Agneris Guzman
Medicaid Director
Office of Economic Assistance
to the Medically Indigent
G.P.O. Box 70184
San Juan, PR 00936
(809) 765-1230

Celeste Benitez
Secretary of Education
Dept. of Education
P.O. Box 759
Hato Rey, PR 00919
(809) 764-6144

Roberto Varela-Flores, MD, MPH
MCH, Dept of Health
Commonwealth of Puerto Rico
Call Box 70184
San Juan, PR 00936
(809) 754-9580

Miquel Valencia-Prado, MD
Acting Director
MCH & CSHN
Dept of Health
Commonwealth of Puerto Rico
Call Box 70184
San Juan, PR 00936
(809) 767-0870

— Rhode Island —

Robert J. Palumbo
Acting Associate Director for Medical Services
Department of Human Services
600 New London Avenue
Cranston, RI 02920
(401) 464-3575

Peter McWalters
Commissioner of Education
State Dept. of Education
22 Hayes Street
Providence, RI 02908
(401) 277-2031

Larry Reynolds
Div of Family Health
RI Dept of Health
Three Capitol Hill
Providence, RI 02908-5098
(401) 277-2312

Peter Simon, MD, MPH
Asst Medical Director
Services for Handicapped Children
RI Dept of Health
Three Capitol Hill
Providence, RI 02908-5098
(401) 277-2312

Donald Sullivan
EPSDT Coordinator

— South Carolina —

Eugene Laurent, Ph. D.
Executive Director
Health and Human Services
Finance Commission
P.O. Box 8206
Columbia, SC 29202-8206
(803) 253-6100

Barbara S. Nielsen
State Superintendent of Edc.
State Dept. of Education
1006 Rutledge Building
1429 Senate Street
Columbia, SC 29201
(803) 734-8492

Marie C. Meglen, MS, CNM
Director, Bureau of MCH
SC Dept of Health & Environ Control
2600 Bull Street
Columbia, SC 29201
(803) 737-4190

Linda Price
Director
Div of Children's Rehab Serv
SC Dept of Health & Environ Control
Robert Mills Complex, Box 101106
2600 Bull Street
Columbia, SC 29211
(803) 737-4050

Kay Hyatt
EPSDT Coordinator

— South Dakota —

David Christensen
Program Administrator
Medical Services
Department of Social Services
700 Governors Drive
Pierre, SD 57501-2291
(605) 773-3495

John A. Bonaiuto
Secretary of Education
Dept. of Edc. and Cultural Affairs
700 Governors Drive
Pierre, SD 57501
(605) 773-3134

Sandra Durick
Director, MCH, CSHS Programs
SD Dept of Health
118 W. Capitol
Pierre, SD 57501
(605) 773-3737

Art Fecht
EPSDT Coordinator

— Tennessee —

Manny Martins
Assistant Commissioner
Bureau of Medicaid
729 Church Street
Nashville, TN 37247-6501
(615) 741-0213

Charles E. Smith
Commissioner of Education
State Dept. of Education
100 Cordell Hull Building
Nashville, TN 37219
(615) 741-2731

Tennessee (contd)

Jeanece Seals, MS, RD
Director, MCH Programs
TN Dept of Hlth & Environ
525 Cordell Hull Bldg
Nashville, TN 37247-4701
(615) 741-0323

Judith Womack, RN
Coordinator
Children's Special Services
TN Dept of Hlth & Environ
525 Cordell Hull Bldg
Nashville, TN 37247-4701
(615) 741-7353

Janice Thornton
EPSDT Coordinator

— Texas —

Randy Washington
Deputy Commissioner for Health Care Services
Dept. of Human Services
P.O. Box 149030
Austin, TX 78714-9030
(512) 450-3050

Lionel R. Meno
Commissioner of Education
William B. Travis Building
1701 North Congress Avenue
Austin, TX 78701-1494
(512) 463-8985

Walter P. Peter, Jr., MD
Director, Bureau of MCH
TX Dept of Health
1100 West 49th Street
Austin, TX 78756
(512) 458-7700

John E. Evans, MHA
Chief, Bureau of Chronically Ill & Disabled Children Serv
TX Dept of Health
1100 West 49th Street
Austin, TX 78756-3179
(512) 458-7355

Bridgit Cook
EPSDT Coordinator

— Utah —

Rod Betit
Director
Division of Health Care Financing
Utah Dept. of Health
P.O. Box 16580
Salt Lake City, UT 84116-0580
(801) 538-6406

Scott W. Bean
Superintendent of Public Instruction
State Office of Education
250 East 500 South
Salt Lake City, UT 84111
(801) 538-7510

Kathleen Glasheen, RN, MS
Director, Child Hlth Bureau
Utah Dept of Health
Cannon Building-Box 16650
288 North 1460 West
Salt Lake City, UT 84116-0650
(801) 584-6140

George W. Delaven, MD
Director, Children's Special Health Services Bureau
Utah Dept of Health
Cannon Building
288 North 1460 West
Salt Lake City, UT 84116-0650
(801) 538-6957

Gail Rapp
EPSDT Coordinator

— Vermont —

Kent Stoneman
Director
Division of Medicaid
Department of Social Welfare
Agency of Human Services
103 South Main Street
Waterbury, VT 05671-1102
(802) 241-2880

Richard P. Mills
Commissioner of Education
State Dept. of Education
120 State Street
Montpelier, VT 05602-2703
(802) 828-3135

Patricia Berry
Director, Div of Local Hlth
VT Dept of Health
1193 North Avenue
P.O. Box 70
Burlington, VT 05401
(802) 863-7347

Carol B. Hassler, MD
Director
Handicapped Children's Services
VT Dept of Health
1193 North Avenue
P.O. Box 70
Burlington, VT 05401
(802) 863-7338

Jeanne Richardson
EPSDT Coordinator

— Virginia —

Bruce Kozlowski
Director
Department of Medical
Assistance Services
Suite 1300
600 East Broad Street
Richmond, VA 23219
(804) 786-8099

Joseph A. Spagnolo, Jr.
Superintendent of Public Instruction
State Dept. of Education
James Monroe Building
Fourteenth & Franklin Streets
Richmond, VA 23216-2060
(804) 225-2023

Alice Linyear, MD
Director, Bureau of MCH
Virg. Dept of Health
1500 East Main St
P.O. Box 2448
Richmond, VA 23218
(804) 786-7367

Nancy Bullock, RN, MPH
Director, Children's Specialty Serv
Bureau of MCH
Virg. Dept of Health
1500 East Main Street
Room 135, P.O. Box 2448
Richmond, VA 23218
(804) 786-7367

Gertrude Dyson
EPSDT Coordinator

— Virgin Islands —

Myriam James
Director
Bureau of Health Insurance
and Medical Assistance
3d Street/Estate Thomas
Charlotte Amalie
St. Thomas, VI 00802
(809) 774-4624

Linda Creque
Commissioner of Education
Dept. of Education
44-46 Kongens Gade
Charlotte Amalie, VI 00802
(809) 774-2810

Joyce Lebron
Acting MCH Director
FB/MCH
Knud Hansen Facility
48 Sugar Estate
St. Thomas, VI 00802
(809) 776-3580

— Washington —

James A. Peterson
Assistant Secretary, Medical Assistance
Department of Social and
Health Services
P.O. Box 45080
Olympia, WA 98504-5080
(206) 753-1777

Judith A. Billings
Superintendent of Public Instruction
State Dept. of Public Instruction
Old Capitol Bldg., Washington & Legion
P.O. Box 47200
Olympia, WA 98504
(206) 586-6904

Maxine Hayes, MD, MPH
Assistant Secretary
Div of Parent Child Hlth Serv
Dept of Health
Mailstop LC-11A
Olympia, WA 98504
(206) 753-7021

Cathy Chapman, RN, MN
Program Manager, CSHN
Div of Parent Child Hlth Serv
Dept of Health
Mailstop LC-11A
Olympia, WA 98504
(206) 753-0908

Amandalei Bennett
EPSDT Coordinator

— West Virginia —

Ann Stottlemyer
Director of Medical Services
Department of Health and Human Resources
Building 6, State Capitol Complex
Charleston, WV 25305
(304) 926-1700

Henry Marockie
State Superintendent of Schools
State Dept. of Education
1900 Kanawha Boulevard, East
Building 6, Room B-358
Charleston, WV 25305
(304) 558-2681

Pat Moss, MSW, ACSW
Director
Office of Maternal and Child Health
WV Dept of Health/Human Serv
1411 Virginia Street, East
Charleston, WV 25301
(304) 558-5388

Pat Kent, MSW
Administrative Director
Div of Handicapped Children
WV Dept of Health/Human Serv
1116 Quarrier Street
Charleston, WV 25301
(304) 558-6330

Joan Faris, MSN
EPSDT Coordinator

— Wisconsin —

Kevin Piper
Director
Bureau of Health Care Financing
Department of Health and Social Services
P.O. Box 309
Madison, WI 53701-0309
(608) 266-2522

Herbert J. Grover
Superintendent of Public Instruction
State Dept. of Public Instruction
125 South Webster Street
P.O. Box 7841
Madison, WI 53707
(608) 266-1771

Ann Haney
Administrator
Family and Community Hlth Section
Wisc. Div of Health
Dept of Hlth and Social Serv
One West Wilson Street
P.O. Box 309
Madison, WI 53701-0309
(608)266-2003

Gerard Simono
Supervisor
Wisc. Division of Health
Dept of Hlth and Social Serv
One West Wilson Street
P.O. Box 309
Madison, WI 53701-0309
(608) 266-3886

Kay Miller
EPSDT Coordinator

— WYOMING —

Kenneth C. Kamis
Administrator
Division of Health Care Financing
Department of Health and Social Services
6101 Yellowstone Road
Cheyenne, WY 82002-0710
(307) 777-7531

Diana J. Ohman
State Superintendent of Public Instruction
State Dept. of Education
2300 Capitol Avenue, 2nd Floor
Hathaway Building
Cheyenne, WY 82002-0050
(307) 777-7675

J. Richard Hillman, MD, PhD
Administrator, Family Hlth Serv
Div of Health/Medical Serv
Wyoming Dept of Health
Hathaway Building
Cheyenne, WY 82002-0710
(307) 777-6186

John Harper
Program Manager
Children's Health Services
Div of Health/Medical Serv
Wyoming Dept of Health
Hathaway Building
Cheyenne, WY 82002-0710
(307) 777-7941

Linda O'Grady
EPSDT Coordinator

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HEALTH AND HUMAN SERVICES
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